ARTICLE 2. LONG TERM CARE INSURANCE COVERAGE

Rule 1. General Provisions

760 IAC 2-1-1 Applicability and scope

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 1. Except as otherwise specifically provided, this article applies to the following:

(1) All long term care insurance policies, certificates, or subscriber agreements delivered or issued for delivery, in Indiana on or after the effective date hereof, by insurers.

(2) Fraternal benefit societies.

(3) Nonprofit health, hospital, and medical service corporations.

(4) Prepaid health plans.

(5) Health maintenance organizations and all similar organizations.

(Department of Insurance; 760 IAC 2-1-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 856; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

Rule 2. Definitions

760 IAC 2-2-1 Policy definitions

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 1. (a) No long term care insurance policy, certificate, or subscriber agreement delivered, or issued for delivery, in Indiana shall contain the terms set forth in this rule, unless the terms are defined in the policy and the definitions satisfy the requirements in this section.

(b) All providers of services, including, but not limited to:

(1) skilled nursing facility;

(2) extended care facility;

(3) intermediate care facility;

(4) convalescent nursing home;

(5) personal care facility; and

(6) home care agency;

shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

(c) The definitions in this rule apply throughout this article. *(Department of Insurance; 760 IAC 2-2-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 856; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-2-2 "Acute condition" defined

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 2. "Acute condition" means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status. *(Department of Insurance; 760 IAC 2-2-2; filed Oct 30, 1992, 12:00 p.m.: 16 IR 856; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-2-3 "Adult day care" defined

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 3. "Adult day care" means a program for six (6) or more individuals, of social and health related services provided during

the day in a community group setting for the purpose of supporting frail, impaired, elderly, or other adults with disabilities who can benefit from care in a group setting outside the home. *(Department of Insurance; 760 IAC 2-2-3; filed Oct 30, 1992, 12:00 p.m.: 16 IR 857; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-2-4 "Home health care services" defined

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 4. "Home health care services" means medical and nonmedical services provided to ill, disabled, or infirm persons in their residences. Such services may include, but are not limited to, the following:

(1) Home health nursing services.
(2) Home health aide services.
(3) Homemaker services.
(4) Assistance with activities of daily living.
(5) Respite care services.

(Department of Insurance; 760 IAC 2-2-4; filed Oct 30, 1992, 12:00 p.m.: 16 IR 857; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-2-5 "Medicare" defined

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 5. "Medicare" means "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended", or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof", or words of similar import. *(Department of Insurance; 760 IAC 2-2-5; filed Oct 30, 1992, 12:00 p.m.: 16 IR 857; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-2-6 "Mental or nervous disorder" defined

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 6. "Mental or nervous disorder" includes only neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder. *(Department of Insurance; 760 IAC 2-2-6; filed Oct 30, 1992, 12:00 p.m.: 16 IR 857; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-2-7 "Personal care" defined

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 7. "Personal care" means the provision of hands-on services to assist an individual with activities of daily living (such as bathing, eating, dressing, transferring, and toileting). *(Department of Insurance; 760 IAC 2-2-7; filed Oct 30, 1992, 12:00 p.m.: 16 IR 857; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-2-8 "Skilled nursing care", "intermediate care", and "home care" defined

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 8. "Skilled nursing care", "intermediate care", "home care", and other services shall be defined in relation to the level of skill required, the nature of the care, and the setting in which care must be delivered. *(Department of Insurance; 760 IAC 2-2-8;*

filed Oct 30, 1992, 12:00 p.m.: 16 IR 857; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

Rule 3. Policy Practices and Provisions

760 IAC 2-3-1 Individual long term care policies

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 1. (a) The terms "guaranteed renewable" and "noncancellable" shall be used in an individual long term care insurance policy only with further explanatory language in accordance with the disclosure requirements of 760 IAC 2-4.

(b) A long term care insurance policy issued to an individual shall not contain renewal provisions other than "guaranteed renewable" or "noncancellable".

(c) The term "guaranteed renewable" may be used only when:

(1) the insured has the right to continue the long term care insurance in force by the timely payment of premiums;

(2) when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force; and

(3) the insurer cannot decline to renew, except that rates may be revised by the insurer on a class basis.

(d) The term "noncancellable" may be used only when:

(1) the insured has the right to continue the long term care insurance in force by the timely payment of premiums; and

(2) the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

(Department of Insurance; 760 IAC 2-3-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 857; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-3-2 Exclusions

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 2. A policy, certificate, or subscriber agreement may not be delivered or issued for delivery in Indiana as long term care insurance if the policy, certificate, or subscriber agreement limits or excludes coverage by type of illness, treatment, medical condition, or accident, except as follows:

(1) Preexisting conditions or diseases.

(2) Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's disease or related degenerative and dementing illnesses.

(3) Alcoholism and drug addiction.

(4) Illness, treatment, or medical condition arising out of:

- (A) war or act of war (whether declared or undeclared);
- (B) participation in a felony, riot, or insurrection;
- (C) service in the armed forces or units auxiliary thereto;
- (D) suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury; or
- (E) aviation (this exclusion applies only to nonfare paying passengers).

(5) Treatment provided in a government facility, unless otherwise required by law as follows:

- (A) Services for which benefits are available under any of the following:
  - (i) Medicare or other governmental program (except Medicaid).
  - (ii) Any state or federal workers' compensation.
  - (iii) Employer's liability or occupational disease law.
  - (iv) Any motor vehicle no-fault law.
- (B) Services provided by a member of the covered person's immediate family.
- (C) Services for which no charge is normally made in the absence of insurance.

This section is not intended to prohibit exclusions and limitations by type of provider or territorial limitations. *(Department of Insurance; 760 IAC 2-3-2; filed Oct 30, 1992, 12:00 p.m.: 16 IR 858; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-3-3 Termination; extension of benefits

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 3. Termination of long term care insurance shall not prejudice any benefits payable for institutionalization if the institutionalization began while the long term care insurance was in force and which institutionalization continues without interruption after termination. The extension of benefits beyond the period the long term care insurance was in force may be limited to the following:

(1) The duration of the benefit period, if any.

(2) Payment of the maximum benefits, if any.

Further, such extension of benefits may be subject to any policy waiting period and all other applicable provisions of the policy. *(Department of Insurance; 760 IAC 2-3-3; filed Oct 30, 1992, 12:00 p.m.: 16 IR 858; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-3-4 Group long term care policies

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 4. (a) Group long term care insurance policies, certificates, or subscriber agreements issued in Indiana on or after the effective date of this article shall provide covered individuals with a basis for continuation or conversion of coverage.

(b) As used in this article, "a basis for continuation of coverage" means a policy provision which maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium. Group policies which contain incentives to use certain providers and/or facilities, and group policies which provide a restricted list of providers and/or facilities shall provide continuation of benefits which are substantially equivalent to the benefits of the existing group policy. The commissioner shall make a determination as to the substantial equivalency of benefits. The commissioner shall consider the differences between managed care and nonmanaged care plans, including, but not limited to, the following:

(1) Provider system arrangements.

(2) Service availability.

(3) Benefit levels.

(4) Administrative complexity.

(c) As used in this article, "a basis for conversion of coverage" means a policy provision which requires that an individual:

(1) whose coverage under the group policy would otherwise terminate or has been terminated for any reason; and

(2) who has been continuously insured under the group policy (and any group policy which it replaced) for at least six (6) months immediately prior to termination;

shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

(d) As used in this article, "converted policy" means an individual policy of long term care insurance providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers and/or facilities, the commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and nonmanaged care plans, including, but not limited to, the following:

(1) Provider system arrangements.

(2) Service availability.

(3) Benefit levels.

(4) Administrative complexity.

(e) In order to maintain uninterrupted coverage, written application for the converted policy must be made and the first premium due, if any, must be paid as directed by the insurer not later than thirty-one (31) days after termination of coverage under the group policy or thirty-one (31) days after the date notification of conversion rights is mailed to the certificate holder, whichever

is later. The converted policy shall be issued effective on the day following the termination of coverage under the group policy and shall be renewable annually.

(f) If the group policy from which conversion is made:

(1) did not replace previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made; or

(2) replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

(g) Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

(1) termination of the individual's group coverage resulted from the individual's failure to make any required payment of premium or contribution when due; or

(2) the terminating coverage is replaced not later than thirty-one (31) days after termination, by group coverage effective on the day following the termination of coverage:

(A) providing benefits identical to those provided by the terminating coverage or providing benefits which the commissioner determines to be substantially equivalent to or in excess of the benefits provided by the terminating coverage;

(B) the premium is calculated in a manner consistent with the requirements of subsection (f); and

(C) the new policy provides coverage to all individuals previously covered under the replaced policy.

(h) Notwithstanding any other provision of this rule, a converted policy issued to an individual may provide for a reduction of benefits payable to an individual only if:

(1) at the time of conversion, the individual is covered by another long term care insurance policy which provides benefits on the basis of incurred expenses;

(2) the benefits provided by the other long term care policy together with the full benefits provided by the converted policy would result in payment of more than one hundred percent (100%) of the incurred expenses; and

(3) the reduction in benefits may only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

(i) The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

(j) Notwithstanding any other provision of this rule, any insured individual whose eligibility for group long term care coverage is based upon his or her relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship. *(Department of Insurance; 760 IAC 2-3-4; filed Oct 30, 1992, 12:00 p.m.: 16 IR 858; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-3-5 Replacement

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 5. If a group long term care policy, certificate, or subscriber agreement is replaced by another group long term care policy, certificate, or subscriber agreement issued to the same policyholder or to the members of the previous policyholder's group, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

(1) shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

(2) shall not vary or otherwise depend on the individual's health or disability status, claim experience, or use of long term care services.

(Department of Insurance; 760 IAC 2-3-5; filed Oct 30, 1992, 12:00 p.m.: 16 IR 859; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-3-6 Premiums

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 6. The premiums charged to an insured for long term care insurance shall not increase due to either:

(1) the increasing age of the insured at ages beyond sixty-five (65); or

(2) the duration the insured has been covered under the policy.

This limitation shall not be required of life insurance policies or riders containing accelerated long term care benefits. *(Department of Insurance; 760 IAC 2-3-6; filed Dec 31, 1992, 9:00 a.m.: 16 IR 1391; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 4. Required Disclosure Provisions

760 IAC 2-4-1 Renewability provisions

Authority: IC 27-8-12-7
Affected: IC 27-8-12-10.6

Sec. 1. (a) Individual long term care insurance policies shall contain a renewability provision. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and the duration of the term of coverage for which the policy may be renewed. This section shall not apply to policies which do not contain a renewability provision, and under which the policies' right to nonrenew is reserved solely to the policyholder.

(b) All riders or endorsements added to an individual long term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured, except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long term care insurance policy. After the date of policy issue, any rider or endorsement which increases benefits or coverage which also increases the premium during the policy term must be accepted to in writing signed by the insured, except if the increased benefits or coverage are required by law. If a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider, or endorsement.

(c) A long term care insurance policy or certificate which provides for the payment of benefits based on standards described as “usual and customary”, “reasonable and customary”, or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

(d) If a long term care insurance policy, certificate, or subscriber agreement contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy, certificate, or subscriber agreement and shall be labeled as “Preexisting Condition Limitations”.

(e) A long term care insurance policy, certificate, or subscriber agreement containing any limitations or conditions for eligibility other than those prohibited in IC 27-8-12-10.6 shall set forth a description of such limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy, certificate, or subscriber agreement and shall label such paragraph “Limitations or Conditions on Eligibility for Benefits”.

(f) Life insurance policies which provide an accelerated benefit for long term care are required to include a disclosure statement:

(1) at the time of application for the policy or rider; and

(2) at the time the accelerated benefit payment request is submitted;

that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. *(Department of Insurance; 760 IAC 2-4-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 860; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 5. Prohibition Against Post-Claims Underwriting

760 IAC 2-5-1 Application; medication

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 1. (a) All applications for long term care insurance policies, certificates, or subscriber agreements except those which are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

(b) If an application for long term care insurance contains a question which asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

(c) If the medications listed in such application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy, certificate, or subscriber agreement shall not be rescinded for that condition. *(Department of Insurance; 760 IAC 2-5-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 860; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-5-2 Language of application; supplemental information

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 2. Except for policies, certificates, or subscriber agreements which are guaranteed issue, the following apply:

(1) The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long term care insurance policy, certificate, or subscriber agreement: "Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your [policy] [certificate] [subscriber agreement].".

(2) The following language, or language substantially similar to the following, shall be set out conspicuously on the long term care insurance policy, certificate, or subscriber agreement at the time of delivery: "Caution: The issuance of this long term care insurance [policy] [certificate] [subscriber agreement] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your [policy] [certificate] [subscriber agreement]. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address].".

(3) Prior to issuance of a policy, certificate, or subscriber agreement to an applicant eighty (80) years of age or older, the insurer shall obtain one (1) of the following:

(A) A report of a physical examination.
(B) An assessment of functional capacity.
(C) An attending physician's statement.
(D) Copies of medical records.

(Department of Insurance; 760 IAC 2-5-2; filed Oct 30, 1992, 12:00 p.m.: 16 IR 860; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-5-3 Completed application or enrollment form

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 3. A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy, certificate, or subscriber agreement unless it was retained by the applicant at the time of application. *(Department of Insurance; 760 IAC 2-5-3; filed Oct 30, 1992, 12:00 p.m.: 16 IR 861; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-5-4 Records

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 4. Every insurer or other entity selling or issuing long term care insurance benefits shall maintain a record of all policy, certificate, or subscriber agreement rescissions, both statewide and country wide, except those which the insured voluntarily effectuated and shall annually furnish this information to the insurance commissioner in the format prescribed by the National Association of Insurance Commissioners. *(Department of Insurance; 760 IAC 2-5-4; filed Oct 30, 1992, 12:00 p.m.: 16 IR 861; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 6. Home Health Care Benefits in Long Term Care Insurance Policies

760 IAC 2-6-1 Minimum standards for home health and community care benefits

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 1. (a) A long term care insurance policy, certificate, or subscriber agreement shall not, if it provides benefits for home health and community care services, limit or exclude benefits as follows:

(1) By requiring that the insured/claimant need skilled care in a skilled nursing facility if home health care services were not provided.

(2) By requiring that the insured/claimant first or simultaneously receive nursing and/or therapeutic services in a home, community, or institutional setting before home health care services are covered.

(3) By limiting eligible services to services provided by registered nurses or licensed practical nurses.

(4) By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification.

(5) By requiring that the insured/claimant have an acute condition before home health care services are covered.

(6) By limiting benefits to services provided by Medicare-certified agencies or providers.

(7) By excluding coverage for personal care services provided by a home health aide.

(8) By requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service.

(9) By excluding coverage for adult day care services.

(b) Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy, certificate, or subscriber agreement.

(c) A long term care insurance policy, certificate, or subscriber agreement, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half (1/2) of one (1) year's coverage available for nursing home benefits under the policy, certificate, or subscriber agreement, at the time covered home health or community care services are being received. This requirement shall not apply to policies, certificates, or subscriber agreements issued to residents of continuing care retirement communities. *(Department of Insurance; 760 IAC 2-6-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 861; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 7. Inflation Protection Offer

760 IAC 2-7-1 General provisions

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 1. (a) Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature. An inflation protection feature shall provide at least one (1) of the following:

(1) Increase benefit levels annually to be compounded annually at a rate not less than five percent (5%).

(2) Guarantee the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be more than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent (5%) for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made.

(3) Cover a specified percentage of actual or reasonable charges and do not include a maximum specified indemnity amount or limit.

(b) Inflation protection benefit increases under a policy which contains such benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

(c) An offer of inflation protection which provides for automatic benefit increases shall include an offer of a premium, which the insurer expects to remain constant. Such offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

(d) Inflation protection as provided in subsection (a) shall be included in a long term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder. The rejection shall be considered a part of the application and shall state: "I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection and I reject inflation protection.

_____
(Signature of Applicant(s))".

(Department of Insurance; 760 IAC 2-7-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 862; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-7-2 Group policy; exception

Authority: IC 27-8-12-7
Affected: IC 27-8-5-17; IC 27-8-12

Sec. 2. Where the policy is issued to a group, the required offer under section 1 of this rule shall be made to the group policyholder; except, if the policy is issued to a group defined in IC 27-8-5-17 other than to a continuing care retirement community, the offering shall be made to each proposed certificate holder. *(Department of Insurance; 760 IAC 2-7-2; filed Oct 30, 1992, 12:00 p.m.: 16 IR 862; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-7-3 Accelerated long term care benefits

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 3. The offer under section 1 of this rule shall not be required of life insurance policies or riders containing accelerated long term care benefits. *(Department of Insurance; 760 IAC 2-7-3; filed Oct 30, 1992, 12:00 p.m.: 16 IR 862; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-7-4 Outline of coverage

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 4. Insurers shall include the following information in or with the outline of coverage:

(1) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty (20) year period.

(2) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall also disclose the magnitude of the potential premiums the applicant would need to pay at seventy-five (75) and eighty-five (85) years of age for benefit increases.

(3) An insurer may use a reasonable hypothetical or a graphic demonstration, for the purposes of this disclosure.

(Department of Insurance; 760 IAC 2-7-4; filed Oct 30, 1992, 12:00 p.m.: 16 IR 862; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

Rule 8. Application Forms and Replacement Coverage

760 IAC 2-8-1 Questions

Authority: IC 27-8-12-7
Affected: IC 27-8-5-16; IC 27-8-12

Sec. 1. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long term care insurance policy, certificate, or subscriber agreement in force or whether a long term care policy, certificate, or subscriber agreement is intended to replace any other accident and sickness or long term care policy, certificate, or subscriber agreement presently in force:

(1) Do you have another long term care insurance policy or certificate in force (including health care service contract, or health maintenance organization contract)?

(2) Did you have another long term care insurance policy or certificate in force during the last twelve (12) months? If so:

(A) with which company; and

(B) if that policy lapsed, when did it lapse?

(3) Are you covered by Medicaid?

(4) Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?

A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing such questions may be used. With regard to a replacement policy issued to a group defined by IC 27-8-5-16(1), the questions in this section may be modified only to the extent necessary to elicit information about health or long term care insurance policies other than the group policy being replaced; provided, however, that the certificate holder has been notified of the replacement. *(Department of Insurance; 760 IAC 2-8-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 862; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-8-2 Any other health insurance policies

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 2. (a) Agents shall list any other health insurance policies they have sold to the applicant.

(b) Agents shall list policies sold which are still in force.

(c) Agents shall list policies sold in the past five (5) years which are no longer in force. *(Department of Insurance; 760 IAC 2-8-2; filed Oct 30, 1992, 12:00 p.m.: 16 IR 863; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-8-3 Notice regarding replacement of accident and sickness or long term care insurance

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 3. Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its agent, shall furnish the applicant, prior to issuance or delivery of the long term care insurance policy, a notice regarding replacement of accident and sickness or long term care coverage. One (1) copy of such notice shall be retained by the applicant, and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING
REPLACEMENT OF ACCIDENT AND SICKNESS
OR LONG TERM CARE INSURANCE
[Insurance company's name and address]
SAVE THIS NOTICE! IT MAY BE IMPORTANT
TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long term care insurance and replace it with a long term care insurance policy to be issued by [company name]. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance

protection available to you under the new policy. You should review this new coverage carefully, comparing it with all accident and sickness or long term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT [BROKER OR OTHER REPRESENTATIVE]: (Use additional sheets, as necessary.) I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present coverage.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

_____
(Signature of Agent, Broker or Other Representative)

_____
[Typed Name and Address of Agent or Broker]

The above "Notice to Applicant" was delivered to me on:

_____
(Date)

_____
(Applicant's Signature)

(Department of Insurance; 760 IAC 2-8-3; filed Oct 30, 1992, 12:00 p.m.: 16 IR 863; errata filed Jan 19, 1993, 10:00 a.m.: 16 IR 1514; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-8-4 Direct response solicitations

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 4. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long term care coverage to the applicant upon issuance of the policy, certificate, or subscriber agreement. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING
REPLACEMENT OF ACCIDENT AND SICKNESS
OR LONG TERM CARE INSURANCE
[Insurance company's name and address]
SAVE THIS NOTICE! IT MAY BE IMPORTANT
TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long term care insurance and replace it with the long term care insurance [policy] [certificate] [subscriber agreement] delivered herewith issued by [company name]. Your new [policy] [certificate] [subscriber agreement] provides thirty (30) days within which you may decide, without cost, whether you desire to keep the [policy] [certificate] [subscriber agreement]. For your

own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new [policy] [certificate] [subscriber agreement].

You should review this new coverage carefully, comparing it with all accident and sickness or long term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long term care coverage is a wise decision.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

(Company Name)

(Department of Insurance; 760 IAC 2-8-4; filed Oct 30, 1992, 12:00 p.m.: 16 IR 864; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-8-5 Replacement; notification

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 5. Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy, certificate, or subscriber agreement shall be identified by the insurer, name of the insured, and policy number or address including zip code. Such notice shall be made within five (5) working days from the date the application is received by the insurer or the date the policy, certificate, or subscriber agreement is issued, whichever is sooner. *(Department of Insurance; 760 IAC 2-8-5; filed Oct 30, 1992, 12:00 p.m.: 16 IR 864; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 9. Reporting Requirements

760 IAC 2-9-1 Reporting

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 1. (a) Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long term care insurance policies sold by the agent as a percent of the agent's total annual sales.

(b) Each insurer shall report annually by June 30 the ten percent (10%) of its agents with the greatest percentages of lapses and replacements as measured by subsection (a).

(c) Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long term care insurance.

(d) Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year.

(e) Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year.

(f) For purposes of this rule, "policy" means only long term care insurance and "report" means on a statewide basis. *(Department of Insurance; 760 IAC 2-9-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 865; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 10. Licensing

760 IAC 2-10-1 Licensing

Authority: IC 27-8-12-7
Affected: IC 27-1-15.5-3; IC 27-1-15.5-7.1

Sec. 1. (a) No agent is authorized to market, sell, solicit, or otherwise contact any person for the purpose of marketing long term care insurance until the agent has successfully passed eight (8) hours of approved continuing education courses in long term care and long term care insurance. An agent who completes the eight (8) hours of continuing education required by this subsection during the first two (2) years of a four (4) year license shall also comply with subsection (b) during the second two (2) years of the license.

(b) An agent shall successfully complete five (5) hours of approved continuing education in long term care or long term care insurance every two (2) years for a total of ten (10) hours in every four (4) year license renewal period.

(c) Continuing education courses completed pursuant to subsections (a) and (b) may be used to satisfy the continuing education requirements set forth in IC 27-1-15.5-7.1.

(d) Each insurer shall require an agent to provide documentation certifying that the agent has satisfied the requirements of this rule prior to accepting applications from the agent or paying the agent commission for the sale of long term care coverage. *(Department of Insurance; 760 IAC 2-10-1; filed Oct. 30, 1992, 12:00 p.m.: 16 IR 865; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531; filed Oct 2, 2001, 4:50 p.m.: 25 IR 382)*

Rule 11. Discretionary Powers of Commissioner

760 IAC 2-11-1 Modification or suspension

Authority: IC 27-8-12-7
Affected: IC 4-21.5; IC 27-8-12

Sec. 1. The commissioner may, upon written request and after a hearing under IC 4-21.5, issue an order to modify or suspend a specific provision or provisions of this article with respect to a specific long term care insurance policy, certificate, or subscriber agreement upon a written finding of the following:

(1) The modification or suspension would be in the best interest of the insureds.

(2) The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension.

(3) Any of the following are necessary:

(A) The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long term care.

(B) The policy, certificate, or subscriber agreement is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community.

(C) The modification or suspension is necessary to permit long term care insurance to be sold as part of, or in conjunction with, another insurance product.

(Department of Insurance; 760 IAC 2-11-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 865; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

Rule 12. Reserve Standards

760 IAC 2-12-1 Reserves for policies, certificates, and riders

Authority: IC 27-8-12-7
Affected: IC 27-1-12-10; IC 27-8-12

Sec. 1. (a) When long term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies or certificates, policy reserves for such benefits shall be determined in accordance with IC 27-1-12-10(2)(h). Claim reserves must also be established in the case when such policy, certificate, or rider is in claim status. Reserves for policies, certificates, and riders subject to this section should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long term care benefits. However, in no event shall the reserves for the long term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long term care benefit.

(b) In the development and calculation of reserves for policies, certificates, and riders subject to this section, due regard shall be given to the applicable policy, certificate, or rider provisions, marketing methods, administrative procedures, and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

(1) Definition of insured events.
(2) Covered long term care facilities.
(3) Existence of home convalescence care coverage.
(4) Definition of facilities.
(5) Existence or absence of barriers to eligibility.
(6) Premium waiver provision.
(7) Renewability.
(8) Ability to raise premiums.
(9) Marketing method.
(10) Underwriting procedures.
(11) Claims adjustment procedures.
(12) Waiting period.
(13) Maximum benefit.
(14) Availability of eligible facilities.
(15) Margins in claim costs.
(16) Optional nature of benefit.
(17) Delay in eligibility for benefit.
(18) Inflation protection provisions.
(19) Guaranteed insurability option.

(c) Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

(d) When long term care benefits are provided other than as in subsections (a) and (b), reserves shall be determined using a table established for reserve purposes by a qualified actuary and acceptable to the commissioner. *(Department of Insurance; 760 IAC 2-12-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 865; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 13. Loss Ratio

760 IAC 2-13-1 Relevant factors

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 1. Benefits under individual long term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent (60%), calculated in a manner which provides for adequate reserving of the long term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including

the following:

(1) Statistical credibility of incurred claims experience and earned premiums.
(2) The period for which rates are computed to provide coverage.
(3) Experienced and projected trends.
(4) Concentration of experience within early policy duration.
(5) Expected claim fluctuation.
(6) Experience refunds, adjustments, or dividends.
(7) Renewability features.
(8) All appropriate expense factors.
(9) Interest.
(10) Experimental nature of the coverage.
(11) Policy reserves.
(12) Mix of business by risk classification.
(13) Product features such as long elimination periods, high deductibles, and high maximum limits.

(Department of Insurance; 760 IAC 2-13-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 866; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

Rule 14. Filing Requirements

760 IAC 2-14-1 Approval by commissioner

Authority: IC 27-8-12-7
Affected: IC 27-8-12-17

Sec. 1. (a) Prior to an insurer or similar organization offering group long term care insurance to a resident of this state under IC 27-8-12-17, it shall file for approval with the commissioner evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long term care insurance requirements substantially similar to those adopted in this state.

(b) The commissioner shall review the policy or certificate to determine whether the policy or certificate complies with the requirements of this rule. *(Department of Insurance; 760 IAC 2-14-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 866; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-14-2 Advertising

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 2. (a) Every insurer, health care service plan, or other entity providing long term care insurance or benefits in Indiana shall provide a copy of any long term care insurance advertisement intended for use in Indiana whether through written, radio, or television medium to the commissioner of insurance of this state for review and approval by the commissioner. In addition, all advertisements shall be retained by the insurer, health care service plan, or other entity for at least three (3) years from the date the advertisement was first used.

(b) The commissioner may exempt from subsection (a) any advertising form or material when, in the commissioner's opinion, subsection (a) may not be reasonably applied. *(Department of Insurance; 760 IAC 2-14-2; filed Oct 30, 1992, 12:00 p.m.: 16 IR 867; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 15. Marketing

760 IAC 2-15-1 Standards

Authority: IC 27-8-12-7
Affected: IC 27-4-1-4; IC 27-8-12

Sec. 1. (a) Every insurer, health care service plan, or other entity marketing long term care insurance coverage in this state, directly or through its producers, shall do the following:

(1) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

(2) Establish marketing procedures to assure excessive insurance is not sold or issued.

(3) Display prominently by type, stamp, or other appropriate means, on the first page of the outline of coverage and policy, certificate, or subscriber agreement the following: "Notice to buyer: This [policy] [certificate] [subscriber agreement] may not cover all of the costs associated with long term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all [policy] [certificate] [subscriber agreement] limitations.".

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long term care insurance already has accident and sickness or long term care insurance and the types and amounts of any such insurance.

(5) Every insurer or entity marketing long term care insurance shall establish auditable procedures for verifying compliance with this subsection.

(b) In addition to the practices prohibited in IC 27-4-1-4, the following acts and practices are prohibited:

(1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies, coverage, or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or coverage or to take out a policy of insurance with another insurer.

(2) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(3) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

(Department of Insurance; 760 IAC 2-15-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 867; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

Rule 16. Purchase or Replacement

760 IAC 2-16-1 Appropriateness of recommended purchase

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 1. In recommending the purchase or replacement of any long term care insurance policy, certificate, or subscriber agreement, an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement. *(Department of Insurance; 760 IAC 2-16-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 867; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-16-2 Prohibition against preexisting conditions and probationary periods in replacement policies or certificates

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 2. If a long term care insurance policy, certificate, or subscriber agreement replaces another long term care policy, certificate, or subscriber agreement, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long term care policy, certificate, or subscriber agreement for similar benefits to the extent that similar exclusions have been satisfied under the original policy, certificate, or subscriber agreement. *(Department of Insurance; 760 IAC 2-16-2; filed Oct 30, 1992, 12:00 p.m.: 16 IR 867; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 17. Outline of Coverage

760 IAC 2-17-1 Standard

Authority: IC 27-8-12-7; IC 27-8-12-14
Affected: IC 27-8-12

Sec. 1. (a) The outline of coverage shall be a free-standing document, using no smaller than ten (10) point type.

(b) The outline of coverage shall contain no material of an advertising nature.

(c) Text which is capitalized or underscored in the standard format outline of coverage may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring.

(d) Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

(e) The format for the outline of coverage shall be as follows:

[COMPANY NAME]
[ADDRESS – CITY AND STATE]
[TELEPHONE NUMBER]
LONG TERM CARE INSURANCE
OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

[Except for policies, certificates, or subscriber agreements which are guaranteed issue, the following caution statement, or language substantially similar, must appear in the outline of coverage.]

Caution: The issuance of this long term care insurance [policy] [certificate] [subscriber agreement] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. This policy is [an individual policy of insurance] ([a group policy] which was issued in the [indicate jurisdiction in which group policy was issued]).

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

3. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(a) [Provide a brief description of the right to return – "free look" provision of the policy.]

(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

4. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

(a) [For agents] Neither [insert company name] nor its agents represent Medicare, the federal government, or any state government.

(b) [For direct response] [insert company name] is not representing Medicare, the federal government, or any state government.

5. LONG TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one (1) or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home. This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

6. BENEFITS PROVIDED BY THIS POLICY.

(a) [Covered services, related deductible(s), waiting periods, elimination periods, and benefit maximums.]

(b) [Institutional benefits, by skill level.]

(c) [Noninstitutional benefits, by skill level.]

[Any benefit screens must be explained in this section. If these screens differ for different benefits, explanation of the screen should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified. If activities of daily living (ADLs) are used to measure an insured's need for long term care, then these qualifying criteria or screens must be explained.]

7. LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions.

(b) Noneligible facilities/provider.

(c) Noneligible levels of care, e.g., unlicensed providers, care or treatment provided by a family member, etc.

(d) Exclusions/exceptions.

(e) Limitations.]

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner, operate to qualify payment of the benefits described in (6) above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

8. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

(a) That the benefit level will not increase over time.

(b) Any automatic benefit adjustment provisions.

(c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage.

(d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations.

(e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

9. TERMS UNDER WHICH THE POLICY (OR CERTIFICATE) MAY BE CONTINUED IN FORCE OR DISCONTINUED.

[(a) Describe the policy renewability provisions.

(b) For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy.

(c) Describe waiver of premium provisions or state that there are not such provisions.

(d) State whether or not the company has a right to change premium, and if such a right exists, describe clearly and concisely each circumstance under which premium may change.]

10. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

11. PREMIUM.

[(a) State the total annual premium for the policy.

(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

12. ADDITIONAL FEATURES.

[(a) Indicate if medical underwriting is used.

(b) Describe other important features.]

(Department of Insurance; 760 IAC 2-17-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 868; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

Rule 18. Shopper's Guide

760 IAC 2-18-1 Delivery

Authority: IC 27-8-12-7
Affected: IC 27-8-12-14.5

Sec. 1. (a) A long term care insurance shopper's guide in a format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the commissioner, shall be provided to all prospective applicants of a long term care insurance policy or certificate. Delivery shall be as follows:

(1) In the case of agent solicitations, an agent must deliver the shopper's guide prior to the presentation of an application or enrollment form.

(2) In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form.

(b) Life insurance policies or riders containing accelerated long term care benefits are not required to furnish the guide referenced in subsection (a), but shall furnish the policy summary required under IC 27-8-12-14.5. *(Department of Insurance; 760 IAC 2-18-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 869; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

Rule 19. Penalties

760 IAC 2-19-1 Civil penalties

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 1. In addition to any other penalties provided by the laws or rules of this state, the commissioner may impose a civil penalty against an insurer which has violated the laws or rules. A penalty imposed under this section shall be the greater of:

(1) three (3) times the amount of the commissions paid for each policy involved in the violation; or

(2) ten thousand dollars ($10,000).

(Department of Insurance; 760 IAC 2-19-1; filed Oct 30, 1992, 12:00 p.m.: 16 IR 869; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-19-2 Other sanctions

Authority: IC 27-8-12-7
Affected: IC 27-8-12

Sec. 2. In addition to any other sanction provided under the laws or rules of this state, the commissioner may impose a penalty against the insurance agent who has violated the laws or rules. The penalty shall be the greater of:

(1) three (3) times the amount of the commissions paid for each policy involved in the violation; or

(2) two thousand five hundred dollars ($2,500).

(Department of Insurance; 760 IAC 2-19-2; filed Oct 30, 1992, 12:00 p.m.: 16 IR 870; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

Rule 20. Indiana Long Term Care Program

760 IAC 2-20-1 Authority

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 1. This rule is adopted and promulgated by the department of insurance under IC 27-8-12-7.1. *(Department of Insurance; 760 IAC 2-20-1; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1145; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-2 Purpose

Authority: IC 27-8-12-7.1
Affected: IC 12-10-12; IC 12-15-2

Sec. 2. The purpose of this rule is to:

(1) establish minimum standards for long term care insurance policies, certificates, and riders to qualify for participation in the Indiana long term care program;

(2) establish documentation and reporting requirements for issuers of policies, certificates, or riders to qualify under the Indiana long term care program;

(3) provide full disclosures in the sale of long term care insurance policies, certificates, and riders which qualify under the Indiana long term care program; and

(4) facilitate public understanding regarding long term care insurance and long term care insurance policies, certificates, and riders which qualify under the Indiana long term care program.

(Department of Insurance; 760 IAC 2-20-2; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1145; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2644; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-3 Applicability

Authority: IC 27-8-12-7.1
Affected: IC 12-10-12; IC 12-15-2

Sec. 3. The requirements of this rule apply to any long term care insurance policy, certificate, or rider authorized for sale by the commissioner of the department of insurance as qualifying under the Indiana long term care program under IC 27-8-12-7.1.

(Department of Insurance; 760 IAC 2-20-3; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1145; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2644; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-4 "Activities of daily living" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 4. (a) As used in this rule, "activities of daily living" include each of the following items:

(1) Eating.
(2) Transferring.
(3) Dressing.
(4) Bathing.
(5) Toileting or continence.

(b) The following definitions apply throughout this section:

(1) "Eating" means feeding oneself by getting food into the body from a receptacle, feeding tube, or intravenously.

(2) "Transferring" means moving into or out of a bed, chair, or wheelchair.

(3) "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

(4) "Bathing" means washing oneself by sponge bath in a tub or shower, including the task of getting into or out of the tub or shower.

(5) "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

(6) "Continence" means the ability to maintain control of bowel and bladder function or when unable to maintain control of bowel or bladder function the ability to perform associated personal hygiene, including care for catheter or colostomy bag.

(Department of Insurance; 760 IAC 2-20-4; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1145; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1989; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-5 "Asset disregard" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 5. As used in this rule, "asset disregard" means the total equity value of personal property, assets, and resources not exempt under Medicaid regulations which at a minimum are equal to the sum of qualifying insurance benefit payments made on behalf of the qualified insured in determining eligibility for the Medicaid program under IC 12-15-2. The following are the two (2) types of asset disregard:

(1) "Dollar-for-dollar asset disregard" means the amount of the disregard is equal to the sum of qualifying insurance benefit payments made on behalf of the qualified insured.

(2) "Total asset disregard" means the amount of the disregard is equal to the total sum of assets owned by the qualified insured once the qualified insured has exhausted all qualifying insurance benefits.

(Department of Insurance; 760 IAC 2-20-5; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1145; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2644; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1989; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-6 "Asset protection" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 6. As used in this rule, "asset protection" means the right extended by IC 12-15-39.6 to beneficiaries of qualified long term care insurance policies and certificates to an asset disregard under the Indiana long term care program. *(Department of Insurance; 760 IAC 2-20-6; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1146; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1989; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-7 "Authorized designee" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 7. As used in this rule, "authorized designee" means any person designated in writing to the insurance company by the policyholder or certificateholder of a qualified long term care policy or certificate for purposes of notification under section 36(8) of this rule. *(Department of Insurance; 760 IAC 2-20-7; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1146; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-8 "Average daily private pay rate" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 8. As used in this rule, "average daily private pay rate" means the average daily rate charged by nursing facilities for persons not qualifying for federal or state reimbursement, established annually on a calendar year basis by OMPP for the period immediately preceding the effective date or renewal date of a policy or certificate. *(Department of Insurance; 760 IAC 2-20-8; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1146; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-9 "Case management" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 9. As used in this rule, "case management" includes, but is not limited to, the development of a comprehensive individualized assessment and care plan and, as needed, coordination of appropriate services and the monitoring of the delivery of such services. *(Department of Insurance; 760 IAC 2-20-9; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1146; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-10 "Case management agency" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 10. As used in this rule, "case management agency" means an agency or other entity approved by DDARS as meeting DDARS case management standards contained in the DDARS community and home care services provider manual. *(Department of Insurance; 760 IAC 2-20-10; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1146; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1989; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-11 "Certificate" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 11. As used in this rule, "certificate" means any certificate delivered or issued for delivery in this state under a group long term care policy. *(Department of Insurance; 760 IAC 2-20-11; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1146; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-12 "Certificate form" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 12. As used in this rule, "certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer. *(Department of Insurance; 760 IAC 2-20-12; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1146; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-13 "Certificateholder" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 13. As used in this rule, "certificateholder" means an owner of a qualified long term care insurance certificate or the beneficiary of a qualified long term care certificate. *(Department of Insurance; 760 IAC 2-20-13; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1146; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-14 "Cognitive impairment" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 14. As used in this rule, "cognitive impairment" means confusion or disorientation resulting from a deterioration or loss of intellectual capacity that is not related to or a result of mental illness but which can result from Alzheimer's disease or similar forms of senility or irreversible dementia. This deterioration or loss of intellectual capacity is established through use of standardized tests that reliably measure impairment in the following areas:

(1) Short term or long term memory.
(2) Orientation as to person, place, and time.
(3) Deductive or abstract reasoning.

Cognitive impairment must result in an individual requiring twenty-four (24) hour a day supervision or direct assistance to maintain his or her safety. *(Department of Insurance; 760 IAC 2-20-14; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1146; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-15 "Complex, unstable medical condition" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 15. As used in this rule, "complex, unstable medical condition" means that the individual requires twenty-four (24) hour a day professional nursing observation or professional nursing intervention more than once a day in a setting other than an acute

care wing of a hospital. *(Department of Insurance; 760 IAC 2-20-15; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1147; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-16 "DDARS" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 16. As used in this rule, "DDARS" means the Indiana division of disability, aging, and rehabilitative services. *(Department of Insurance; 760 IAC 2-20-16; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1147; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1989; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-17 "Deficiency in activities of daily living" defined (Repealed)

Sec. 17. *(Repealed by Department of Insurance; filed Feb 9, 1999, 5:02 p.m.: 22 IR 2001)*

760 IAC 2-20-18 "Direct assistance" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 18. As used in this rule, "direct assistance" means that the individual cannot perform an activity of daily living safely or appropriately without continual help or oversight. Direct assistance may vary from requiring a person to physically stand by or set up the activity to the activity being totally performed by others. *(Department of Insurance; 760 IAC 2-20-18; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1147; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-18.1 "Eligible long term care services" defined (Repealed)

Sec. 18.1. *(Repealed by Department of Insurance; filed Feb 9, 1999, 5:02 p.m.: 22 IR 2001)*

760 IAC 2-20-19 "Indiana long term care program" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 19. As used in this rule, the "Indiana long term care program" means the program authorized in IC 27-8-12-7.1 and IC 12-15-39.6. *(Department of Insurance; 760 IAC 2-20-19; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1147; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1989; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-20 "Indiana preadmission screening program" defined (Repealed)

Sec. 20. *(Repealed by Department of Insurance; filed Feb 9, 1999, 5:02 p.m.: 22 IR 2001)*

760 IAC 2-20-21 "Insured event" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 21. (a) Except as specified in subsection (b), as used in this rule, "insured event" means, for the purposes of determining eligibility for benefits under a qualified policy, or certificate, or rider and for determining whether these benefits result in an asset disregard for a qualified insured, that any one (1) of the following criteria is met:

(1) The individual has a deficiency in two (2) or more activities of daily living.
(2) The individual has a cognitive impairment.
(3) The individual has a complex, unstable medical condition.

(b) For qualified policies eligible for favorable tax status, "insured event" means when the policyholder has become a "chronically ill individual" as that term is defined in the Health Insurance Portability and Accountability Act of 1996, P.L.104-191, Sections 321 through 327, hereinafter referred to as "HIPAA 1996". When determining the loss of functional capacity, the policyholder must be unable to perform (without substantial assistance from another individual) two (2) or more of six (6) activities of daily living (as set forth in HIPAA 1996) for a period of at least ninety (90) days. *(Department of Insurance; 760 IAC 2-20-21; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1147; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2644; filed Jul 28, 1997, 1:50 p.m.: 20 IR 3369; errata, 21 IR 111; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-21.1 "Integrated policy" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-10-12; IC 12-15-2

Sec. 21.1. As used in this rule, "integrated policy" refers to any qualified long term care insurance policy or certificate which provides coverage for both long term care facilities and home and community care services. *(Department of Insurance; 760 IAC 2-20-21.1; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2645; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-22 "Issuer" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 22. As used in this rule, "issuer" means:
(1) insurance companies;
(2) fraternal benefit societies;
(3) prepaid health care delivery plans;
(4) health care service plans;
(5) health maintenance organizations; and
(6) any other entity;
delivering or issuing for delivery in this state, long term care policies or certificates. *(Department of Insurance; 760 IAC 2-20-22; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1147; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-22.1 "Long term care facility" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-10-12; IC 12-15-2; IC 16-28

Sec. 22.1. As used in this rule, "long term care facility" means a facility licensed under IC 16-28, including nursing facilities and residential care facilities. *(Department of Insurance; 760 IAC 2-20-22.1; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2645; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-22.2 "Long term care facility policy" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 22.2. As used in this rule, "long term care facility policy" refers to any qualified long term care insurance policy or certificate which provides coverage primarily for care in a long term care facility and does not provide coverage for home and community care. *(Department of Insurance; 760 IAC 2-20-22.2; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2645; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1990; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-23 "Medicaid eligible long term care services" defined (Repealed)

Sec. 23. *(Repealed by Department of Insurance; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2653)*

760 IAC 2-20-24 "Medicaid waiver" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 24. As used in this rule, "Medicaid waiver" refers to the home and community based services waiver for the aged and disabled approved by the United States Department of Health and Human Services Health Care Financing Administration under the provisions of Section 1915(c) of the Social Security Act which allows Indiana to provide certain community and in-home services not covered in the state Medicaid plan, which are instrumental in the avoidance or delay of institutionalization. Indiana's Medicaid waiver services include:

(1) case management;
(2) homemaker;
(3) respite care;
(4) attendant care;
(5) adult day care; and
(6) other services which, independent of the preceding home and community based services, are essential to prevent institutionalization.

(Department of Insurance; 760 IAC 2-20-24; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1148; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-24.1 "Minimum inflation adjusted daily benefit" defined (Repealed)

Sec. 24.1. *(Repealed by Department of Insurance; filed Feb 9, 1999, 5:02 p.m.: 22 IR 2001)*

760 IAC 2-20-25 "OMPP" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 25. As used in this rule, "OMPP" means the Indiana office of medicaid policy and planning. *(Department of Insurance; 760 IAC 2-20-25; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1148; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-26 "Plan of care" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 26. As used in this rule, "plan of care" means a written individualized plan of services developed by a case management agency which specifies the type and frequency of all services required by the individual, the service providers, and the cost of services. *(Department of Insurance; 760 IAC 2-20-26; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1148; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1990; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-26.5 "Policy eligible for favorable tax status" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 27-8-12-7

Sec. 26.5. As used in this rule, "policy eligible for favorable tax status" means any long term care insurance policy or certificate meeting federal standards of HIPAA 1996, including clearly disclosing in the policy and in the outline of coverage that such policy is intended to be a long term care insurance contract eligible for favorable tax status under Section 7702B(b) of Chapter 79 of the Internal Revenue Code of 1986. *(Department of Insurance; 760 IAC 2-20-26.5; filed Jul 28, 1997, 1:50 p.m.: 20 IR 3370; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-27 "Policy form" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 27. As used in this rule, "policy form" means the form on which the policy is delivered or issued for delivery by the issuer. *(Department of Insurance; 760 IAC 2-20-27; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1148; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-28 "Policyholder" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 28. As used in this rule, "policyholder" means an owner of an individual qualified long term care insurance policy or a beneficiary of a qualified individual long term care insurance policy. *(Department of Insurance; 760 IAC 2-20-28; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1148; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-29 "Qualified insured" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-10-12; IC 12-15-2

Sec. 29. As used in this rule, "qualified insured" means the following:

(1) An individual who is either:

(A) the beneficiary of a qualified long term care policy, certificate, or rider approved by the department of insurance; or

(B) enrolled in a prepaid health care delivery plan that provides long term care services and qualifies under this rule.

(2) An individual who is eligible for an asset disregard under a qualified long term care policy, certificate, or rider.

(Department of Insurance; 760 IAC 2-20-29; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1148; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2645; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-30 "Qualified long term care insurance policy or certificate" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6; IC 27-8-12-7

Sec. 30. As used in this rule, "qualified long term care insurance policy or certificate" means:

(1) any long term care insurance policy or certificate qualified for sale to Indiana residents by the department of insurance as meeting standards promulgated under IC 27-8-12-7 and IC 27-8-12-7.1; or

(2) any long term care insurance policy or certificate owned by an Indiana resident purchased under another state's Partnership for Long Term Care Program if the other state's program is similar to the Indiana Long Term Care Program and OMPP has a reciprocity agreement with the other state's Medicaid program.

(Department of Insurance; 760 IAC 2-20-30; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1149; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1990; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-30.1 "Qualified rider" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 27-8-12-7

Sec. 30.1. As used in this rule, "qualified rider" means any long term care insurance rider qualified for sale to Indiana residents by the department of insurance as meeting standards promulgated under IC 27-8-12-7 and IC 27-8-12-7.1. *(Department of Insurance; 760 IAC 2-20-30.1; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2645; filed Jul 28, 1997, 1:50 p.m.: 20 IR 3370; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-31 "Quarterly/annually" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 31. As used in this rule, "quarterly/annually" refers to periods aligning with the state fiscal year of July 1 to June 30. *(Department of Insurance; 760 IAC 2-20-31; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1149; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-31.1 "Residential care facility" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-10-12; IC 12-15-2; IC 16-28

Sec. 31.1. As used in this rule, "residential care facility", also referred to as assisted living facility and alternate care facility, means a facility licensed under IC 16-28 and 410 IAC 16.2-5 which:

(1) provides twenty-four (24) hour a day care and services sufficient to support needs resulting from inability to perform activities of daily living or cognitive impairment;

(2) has a trained and ready to respond employee on duty in the facility at all times to provide care;

(3) provides three (3) meals a day and accommodates special dietary needs;

(4) has written contractual arrangements or otherwise ensures that residents receive the medical care services of a physician or nurse in case of emergency; and

(5) has appropriate methods and procedures for the handling and administration of prescribed medications and treatments.

(Department of Insurance; 760 IAC 2-20-31.1; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2646; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-32 "Service summary" defined

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 32. As used in this rule, "service summary" means a written summary, prepared by an issuer for a qualified insured, which identifies the following:

(1) The specific qualified policy or certificate.

(2) The total benefits paid for services to date.

(3) The amount of benefits qualifying for asset protection.

(Department of Insurance; 760 IAC 2-20-32; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1149; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-32.5 State-set dollar amount

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; 12-15-39.6

Sec. 32.5. As used in this rule, "state-set dollar amount" means the least amount of maximum benefit a policyholder or certificateholder must initially purchase in a qualified policy or certificate to be eligible for a total asset disregard. The state-set dollar amount begins at one hundred forty thousand dollars ($140,000) for qualified policies with an effective date of 1998 or earlier. The state-set dollar amount will increase each year on January 1 by five percent (5%) compounded annually, rounded to the nearest one dollar ($1) increment, and applies to new policies effective during each calendar year. *(Department of Insurance; 760 IAC 2-20-32.5; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1990; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-33 Qualification of long term care insurance policies, certificates, and riders

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 33. (a) No long term care insurance policy, or certificate, or rider shall qualify for participation in the Indiana long term care program unless the long term care insurance policy, or certificate, or rider complies with this rule.

(b) The commissioner of the department of insurance may not approve a long term care facility policy or certificate as a qualified policy or certificate for participation in the Indiana long term care program unless the issuer has an approved qualified integrated policy or certificate.

(c) The commissioner of the department of insurance may not approve a long term care facility policy or certificate eligible for favorable tax status as a qualified policy or certificate for participation in the Indiana long term care program unless the issuer has an approved qualified integrated policy or certificate eligible for favorable tax status.

(d) Long term care insurance policies, and certificates, and riders in force at the effective date of this rule may, with the signed acceptance of the policyholder or certificateholder, be amended to meet the requirements for qualification. *(Department of Insurance; 760 IAC 2-20-33; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1149; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2646; filed Jul 28, 1997, 1:50 p.m.: 20 IR 3370; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-34 Standards for marketing

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6; IC 27-1-15.5-7.1; IC 27-1-15.5-7.3

Sec. 34. No long term care insurance policy, or certificate, or rider may be advertised, solicited, or issued for delivery in this state as a qualified long term care insurance policy, or certificate, or rider which does not meet the requirements of this article and has not been approved by the commissioner of the department of insurance as a qualified long term care insurance policy, or certificate, or rider. Each issuer seeking to qualify a long term care policy, or certificate, or rider for participation in the Indiana long term care program must do the following:

(1) Use applications to be signed by the applicant which indicate, as described as follows, that he or she:

(A) Received from the issuer the current edition of a booklet developed by OMPP titled "What you should know about long term care: The most commonly asked questions about the Indiana Long Term Care Program".

(B) Received a description of the issuer's qualified long term care policy or certificate benefit option meeting the requirements of sections 36.1(2) and 36.2(2) of this rule.

(C) Agrees to the release of information by the issuer to the state as may be needed to evaluate the Indiana long term care program and document a claim for Medicaid asset protection, in the following format:

"CONSENT AND AUTHORIZATION
TO RELEASE INFORMATION

I hereby agree to the release of all records and information pertaining to this long term care policy or certificate by the [insert issuer name] to the State of Indiana for the purposes of documenting a claim for Asset Protection under the State Medicaid program, evaluating the Indiana Long Term Care Program, and meeting Medicaid or Department of Insurance audit requirements.

I understand that the information contained in these records will be used for no purpose other than those stated above, and will be kept strictly confidential by the State of Indiana.

_____ _____
(Signature of Applicant(s)) Date".

(D) Received a graphic comparison showing the differences in premiums and benefits, over at least a twenty (20) year period, between a policy or certificate that increases benefits over the policy or certificate period and a policy or certificate that does not increase benefits.

(2) Obtain a signed statement from all applicants for a qualifying long term care facility policy or certificate indicating that they have been offered a qualifying integrated policy or certificate and declined this option. This statement shall be considered part of the application and shall state the following:

"I have been offered a policy or certificate qualifying under the Indiana Long Term Care Program which provides coverage for both nursing home and home and community care services, and I decline the offer to apply for this coverage.

I understand that in the event I later want to purchase qualifying home and community care benefits through a qualifying rider, I may be required to furnish evidence of insurability and the insurer will have the right to refuse my

request.

I also understand that the cost of purchasing home and community care benefits at a later date will be more expensive, since the premium for these benefits will be based upon my age at the time of such purchase.

_____ _____

Date Signature of Applicant".

(3) Provide to the applicant the option of having the application date of the policy being issued as the effective date. Where the policy is issued to a group and the group designates a day other than the application date as the effective date, any applicant for a certificate of coverage in an amount that meets or exceeds the state-set dollar amount at the time of application will be issued a certificate with coverage equal to the greater of the following:

(A) The certificate value applied for. or

(B) The state-set dollar amount in force on the certificate's effective date. In the event the value increases as a result of this provision, the premium may be adjusted accordingly. An election to choose the lesser value in a certificate shall be supported by a statement signed by the applicant that clearly discloses the certificate will earn dollar-for-dollar asset protection.

(4) Provide to the policyholder or certificateholder upon delivery of a qualified long term care insurance policy or certificate a complete description of the asset protection options under the Indiana long term care program and a description of Medicaid in a format prescribed by OMPP.

(5) Report to the commissioner of the department of insurance all sales involving replacement of existing policies and certificates by qualified policies or certificates within thirty (30) days of the issue date of the newly issued qualified policy or certificate. The report shall include the following:

(A) The name and address of the insured.

(B) The name of the company whose policy or certificate is being replaced.

(C) The name of the agent replacing the coverage.

This report shall also include a comparison of the coverage issued with that being replaced, including a comparison of premiums and an explanation of how the replacement was beneficial to the insured. The replacing issuer shall not cancel, nonrenew, or rescind a replacement policy or certificate for any reason other than nonpayment of premium, material misrepresentation, or fraud.

(6) Provide written evidence to the department of insurance that procedures are in place to assure that no agent or telemarketer will be authorized to market, sell, solicit, or otherwise contact any person for the purpose of marketing a qualified long term care insurance policy or certificate unless the agent or telemarketer has completed fifteen (15) hours of continuing education training on long term care insurance, consisting of eight (8) hours in general long term care and seven (7) hours on the Indiana long term care program specifically.

(7) Include a statement on the outline of coverage, the policy or certificate application, and the front page of the policy or certificate in bold type and in a separate box as follows:

THIS POLICY [CERTIFICATE] QUALIFIES UNDER THE INDIANA LONG TERM CARE INSURANCE PROGRAM FOR MEDICAID ASSET PROTECTION. THIS POLICY [CERTIFICATE] MAY PROVIDE BENEFITS IN EXCESS OF THE ASSET PROTECTION PROVIDED IN THE INDIANA LONG TERM CARE PROGRAM.

(8) For all long term care facility policies or certificates, include a statement on the outline of coverage and the front page of the policy or certificate in bold type and prominently displayed which states: LONG TERM CARE FACILITY POLICY [CERTIFICATE].

(9) Include a statement on the qualified rider in bold type and in a separate box as follows:

THIS RIDER QUALIFIES UNDER THE INDIANA LONG TERM CARE PROGRAM FOR MEDICAID ASSET PROTECTION WHEN ATTACHED TO A LONG TERM

CARE POLICY WHICH ALSO QUALIFIES FOR MEDICAID ASSET PROTECTION. THIS RIDER MAY PROVIDE BENEFITS IN EXCESS OF THE ASSET PROTECTION PROVIDED IN THE INDIANA LONG TERM CARE PROGRAM.

(10) Long term care insurance policies or certificates sold after April 1, 1993, that are not qualified under the Indiana long term care program must include a statement on the outline of coverage, the policy or certificate application, and the front page of the policy or certificate in bold type and in a separate box as follows:

THIS POLICY [CERTIFICATE] DOES NOT QUALIFY FOR MEDICAID ASSET PROTECTION UNDER THE INDIANA LONG TERM CARE PROGRAM. HOWEVER, THIS POLICY [CERTIFICATE] IS AN APPROVED LONG TERM CARE INSURANCE POLICY [CERTIFICATE] UNDER STATE INSURANCE REGULATIONS. FOR INFORMATION ABOUT POLICIES AND CERTIFICATES QUALIFYING UNDER THE INDIANA LONG TERM CARE PROGRAM, CALL THE SENIOR HEALTH INSURANCE INFORMATION PROGRAM OF THE DEPARTMENT OF INSURANCE AT 1-800-452-4800.

(11) Provide that no qualified long term care policy or certificate form shall be sold, transferred, or otherwise ceded to another issuer without first having obtained approval from the commissioner. This provision does not apply to:

(A) any reinsurance agreement or transaction in which the ceding issuer continues to remain directly liable for its insurance obligations or risks under the contracts of insurance subject to the reinsurance agreement; and

(B) the ceding issuer remains responsible for complying with all requirements of sections 37 *[section 37 of this rule was repealed filed Feb 9, 1999, 5:02 p.m.: 22 IR 2001.]* through 42 of this rule.

(12) Except as provided in clause (A), an issuer shall continue to make available for purchase any qualified policy form or certificate form issued that has been approved by the commissioner. The following describe the process and result of discontinuing the availability of a qualified policy form or certificate form:

(A) An issuer may discontinue the availability of a qualified policy form or certificate form if the issuer provides the commissioner, in writing, its decision at least thirty (30) days prior to discontinuing the availability of the form of the qualified policy or certificate. The following shall be considered a discontinuance of the availability of a qualified policy form or certificate form:

(i) The sale or other transfer of a qualified policy form or certificate form to another issuer.

(ii) Failure to actively offer for sale a qualified policy form or certificate form in the previous twelve (12) months.

(iii) A change in the rating structure or methodology unless the issuer complies with the following requirements:

(AA) The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and resultant rates.

(BB) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential which is in the public interest.

(B) An issuer that discontinues the availability of a qualified policy form or certificate form under clause (A) shall not file for approval of a new long term care policy form or certificate form for a period of five (5) years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate. This clause does not apply if one (1) of the following are

met:

(i) An issuer discontinues a qualified policy form or certificate form due to requirements from amendment to this article or IC 27-8-12.

(ii) All existing policyholders and certificateholders of a discontinued qualified policy form or certificate form who are not receiving benefits are notified by the issuer of the availability of the new benefits and provisions of the new qualified policy form by the time of their next renewal date and are offered the opportunity by the issuer to acquire the new benefits and/or provisions by either:

(AA) adding a qualified rider to the original qualified policy, in which case a separate premium, if any, will be calculated for the qualified rider based on the policyholder's original issue age; or

(BB) replacing the existing qualified policy with the new qualified policy form with the premium calculation for the new qualified policy based on the policyholder's original issue age.

This item does not prohibit an issuer for underwriting in accordance with the issuer's established underwriting standards, based on an application for the new qualified policy form or qualified rider.

(iii) The issuer pools the insureds of the existing qualified policy with the issuer's most current largest selling qualified policy for purposes of requesting future rate changes. In the event an issuer does not have another qualified policy in which to pool insureds of their existing qualified policy, the issuer shall pool insureds of the existing qualified policy with their most current largest selling nonqualified policy, or with another of their nonqualified policies as determined by the commissioner for purposes of requesting future rate changes.

(C) An issuer who discontinues selling qualified policies or any insurer who assumes a qualified policy from another insurer must continue to comply with the reporting requirements and maintaining auditing information requirements set forth in this article.

(13) Provide assurances to the department of insurance that in the event a change is made to a qualified policy or certificate that is eligible for favorable tax status that may affect its favorable tax status, the issuer shall disclose this fact to the policyholder or certificateholder prior to the change being made. And, at a minimum, the issuer shall advise the policyholder or certificateholder that they should consult a tax advisor.

(Department of Insurance; 760 IAC 2-20-34; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1149; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2646; errata filed Sep 28, 1994, 3:30 p.m.: 18 IR 268; filed Jul 28, 1997, 1:50 p.m.: 20 IR 3370; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1990; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-35 Minimum benefit standards for qualifying policies, certificates, and riders

Authority: IC 27-8-12-7.1
Affected: IC 12-10-12; IC 12-15-2

Sec. 35. No long term care insurance policy, certificate, or rider may be advertised, solicited, or issued for delivery in this state as a qualified long term care insurance policy, certificate, or rider which does not meet the minimum benefit standards in this section, and which has not been approved by the commissioner of the department of insurance as a qualified long term care insurance policy, certificate, or rider. These minimum standards do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards. These standards are in addition to all other requirements of this article. In order to qualify for participation in the Indiana long term care program, a long term care insurance policy, certificate, or rider shall meet the following:

(1) Provide that maximum benefits be available in dollars and not in days of care.

(2) Include a provision of inflation protection which satisfies at least one (1) of the following criteria:

(A) The policy or certificate covers at least seventy-five percent (75%) of the average daily private pay rate.

(B) The policy or certificate provides for automatic increases in the per diem dollar level in accordance with either the Consumer Price Index or at five percent (5%) each year over the previous year for each year that the contract is in force.

(3) Provide that the unused maximum benefit amount of the policy, certificate, or rider increase proportionately with the inflation protection requirements of subdivision (2).

(Department of Insurance; 760 IAC 2-20-35; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1151; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2649; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-36 Required policy, certificate, and rider provisions

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 36. All qualified policies, certificates, and riders shall meet the following requirements:

(1) Have premiums:

(A) based on the issue age of the applicant; or

(B) level for the life of the policy or certificate.

Nothing in this subdivision shall preclude an issuer from reducing premiums of a policy or certificate or using a policy form or certificate form in which the premiums are no longer required to be paid after a specified period of time.

(2) Include a provision that the policy, certificate, or rider will utilize the insured event criteria, defined in section 21 of this rule, for determining eligibility for benefits and for determining the amount of asset disregard.

(3) Include a provision which, in the event the qualified policy or certificate is about to lapse, offers the policyholder or certificateholder the option to reduce his or her coverage to a lower benefit amount. However, this benefit amount offer, plus the amount of benefits used to date, cannot be less than the minimum benefit amount requirement specified in section 36.1(l) or 36.2(l) of this rule. The issuer need only allow this offer to be exercised one (1) time. Premiums shall be based on the age of the policyholder or certificateholder at the time of the issuance of the original qualified policy or certificate.

(4) Include a provision that, upon sale of a qualified long term care insurance policy or certificate, the issuer shall do the following:

(A) Offer to collect and store the name and address of an individual designated as an authorized designee by the purchaser to be notified when a policy or certificate lapse is imminent. The issuer must obtain a signed statement from purchasers who do not choose to designate an authorized designee that they have been offered this opportunity and declined. It shall be the issuer's responsibility to notify such designee prior to canceling a policy or certificate due to lack of premium payment. The designee notification shall occur no later than fifteen (15) days after the beginning of the thirty (30) day grace period for premium payments. The issuer shall permit the policyholder or certificateholder to periodically update the authorized designee.

(B) Provide at least a ninety (90) day guaranteed reinstatement period for a policyholder or certificateholder whose policy or certificate has lapsed due to nonpayment of premium, who meets the insured event criteria, and who has paid all due and unpaid premiums. The reinstated policy or certificate shall have the same benefits, terms, and premiums as the policy or certificate which lapsed.

(5) Include a provision that benefits shall only be paid after the payment of all other benefits to which the policyholder or certificateholder is otherwise entitled, excluding Medicaid. The issuer shall make reasonable efforts to determine whether benefits are available from other policies or certificates or from Medicare.

(6) Include a provision that the policy form shall not be changed or otherwise modified without the signed acceptance of the policyholder, or include a provision that the certificate form issued under a group long term care policy shall not be changed or otherwise modified without the signed acceptance of the certificateholder.

(7) For purposes of approving any future premium adjustments, all individual qualified policies issued by the same issuer shall be considered a single risk pool and all group qualified policies issued by the same issuer shall be considered a single risk pool, except a group issuer may form a separate risk pool whenever at least two thousand (2,000) certificates are in force for:

(A) a single employer, labor organization, or trust established by a single employer or labor organization;

(B) a single nonprofit association composed of individuals who are or were actively engaged in the same profession, trade, or occupation and organized in good faith for purposes other than obtaining insurance; and

(C) a single nonprofit association created and maintained in good faith for the benefit of its members and not for the purposes of obtaining insurance, in active existence for at least five (5) years, and with a constitution and bylaws and a board with member representation.

Nothing in this subdivision shall preclude an issuer from pooling their qualified and nonqualified policies, certificates, and riders to avoid or reduce the amount of any future premium increase that otherwise might have occurred to the risk pool of qualified policies, certificates, and riders.

(Department of Insurance; 760 IAC 2-20-36; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1152; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2650; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1993; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-36.1 Minimum benefit standards and required policy and certificate provisions for integrated policies

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 36.1. No long term care insurance policy or certificate may be advertised, solicited, or issued for delivery in this state as a qualified integrated policy or certificate which does not meet the minimum benefit standards and required policy and certificate provisions in this section, and which has not been approved by the commissioner of the department of insurance as a qualified long term care insurance policy or certificate. These minimum standards do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards. These standards are in addition to all other requirements of this article. In order to qualify for participation in the Indiana long term care program, an integrated policy or certificate must meet the following:

(1) Contain a maximum benefit amount equivalent to at least three hundred sixty-five (365) times the minimum daily nursing facility benefit defined in subdivision (3)(A).

(2) Offer a maximum benefit amount option equivalent to three hundred sixty-five (365) times the minimum daily nursing facility benefit defined in subdivision (3)(A). Issuers may offer other benefit amount options in addition to this minimum benefit amount option.

(3) At a minimum, upon the initial effective date, provide the following:

(A) A daily nursing facility benefit of at least seventy-five percent (75%) of the average daily private pay rate in nursing facilities rounded to the next highest five dollar ($5) or ten dollar ($10) increment. No policy or certificate shall pay benefits in excess of the actual charges.

(B) A daily home and community based benefit of at least fifty percent (50%) of the daily nursing facility benefit contained in the policy or certificate. No policy or certificate shall pay benefits in excess of the actual charges.

(C) The daily home and community based benefit shall not exceed the daily nursing facility benefit.

(4) If issued on an expense incurred basis, provide benefits which are equal to at least seventy-five percent (75%) of the per diem cost incurred by the insured.

(5) Include a provision that policy or certificate benefits can be used to purchase nursing facility care or home and community based care. Home and community based care shall include, at a minimum, but not be limited to, the following:

(A) Home health nursing.

(B) Home health aide services.

(C) Attendant care.

(D) Respite care.

(E) Adult day care services.

(6) All home and community based services shall include case management services delivered by a case management agency. The issuer may establish a limit on case management benefits. This limit shall not be less than thirteen (13) times the daily nursing home benefit per year. Case management benefits shall not count toward the policy's or certificate's maximum benefit.

(7) Issuers may include benefits for residential care facilities, as defined in section 31.1 of this rule, in an integrated policy or certificate. These policies must:

(A) provide a daily residential care facility benefit of at least fifty percent (50%) and no more than the daily nursing facility benefit contained in the policy or certificate;

(B) if issued on an expense incurred basis, provide a daily residential care facility benefit which does not exceed fifty percent (50%) of the per diem cost incurred by the insured; and

(C) include a provision that policy or certificate benefits can be used to purchase care in a nursing facility or residential care facility.

(Department of Insurance; 760 IAC 2-20-36.1; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2651; errata filed Sep 28, 1994, 3:30 p.m.: 18 IR 268; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1994; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-36.2 Minimum benefit standards and required policy and certificate provisions for long term care facility policies

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 36.2. No long term care insurance policy or certificate may be advertised, solicited, or issued for delivery in this state as a qualified long term care facility policy or certificate which does not meet the minimum benefit standards and required policy and certificate provisions in this section, and which has not been approved by the commissioner of the department of insurance as a qualified long term care insurance policy or certificate. These minimum standards do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards. These standards are in addition to all other requirements of this article. In order to qualify for participation in the Indiana long term care program, a long term care facility policy or certificate must meet the following:

(1) Contain a maximum benefit amount equivalent to at least three hundred sixty-five (365) times the minimum daily nursing facility benefit defined in subdivision (3).

(2) Offer a maximum benefit amount option equivalent to three hundred sixty-five (365) times the minimum daily nursing facility benefit defined in subdivision (3). Issuers may offer other benefit amount options in addition to this minimum benefit amount option.

(3) At a minimum, upon the initial effective date, provide a daily nursing facility benefit of at least seventy-five percent (75%) of the average daily private pay rate in nursing facilities rounded to the next highest five dollar ($5) or ten dollar ($10) increment. No policy or certificate shall pay benefits in excess of the actual charges.

(4) If issued on an expense incurred basis, provide daily nursing facility benefits which are equal to at least seventy-five percent (75%) of the per diem cost incurred by the insured.

(5) Issuers may include benefits for residential care facilities, as defined in section 31.1 of this rule, in a long term care facility policy or certificate. Policies and certificates which include residential care facility benefits must:

(A) provide a daily residential care facility benefit of at least fifty percent (50%) and no more than the daily nursing facility benefit contained in the policy or certificate;

(B) if issued on an expense incurred basis, provide a daily residential care facility benefit which does not exceed fifty percent (50%) of the per diem cost incurred by the insured; and

(C) include a provision that policy or certificate benefits can be used to purchase care in a nursing facility or a residential care facility.

(Department of Insurance; 760 IAC 2-20-36.2; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2652; errata filed Sep 28, 1994, 3:30 p.m.: 18 IR 268; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1995; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-36.3 Minimum benefit standards and required policy and certificate provisions for qualified riders

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 36.3. (a) No long term care insurance rider may be advertised, solicited, or issued for delivery in this state as a qualified rider which does not meet the minimum benefit standards and required provisions in this section, and which has not been approved by the commissioner of the department of insurance as a qualified rider.

(b) An issuer may only attach a qualified rider to a qualified long term care policy sold by the same issuer.

(c) A qualified rider, which provides home and community based services, must provide benefits, at a minimum, but not be limited to, the following:

(1) Home health nursing.

(2) Home health aide services.

(3) Attendant care.

(4) Respite care.

(5) Adult day care services.

(d) All home and community based services covered through the qualified rider shall include case management services delivered by a case management agency. The issuer may establish a limit on case management benefits. This limit shall not be less than thirteen (13) times the daily nursing home benefit per year. Case management benefits shall not count toward the policy or certificate's maximum benefit.

(e) At a minimum, upon the initial effective date of the qualified rider, which provides home and community based services, the qualified rider must provide the following:

(1) A daily home and community based benefit of at least fifty percent (50%) of the then current daily nursing facility benefit

of the long term care facility policy or certificate. No policy or certificate shall pay benefits in excess of the actual charges.

(2) The daily home and community based benefit shall not exceed the then current daily nursing facility benefit of the long term care facility policy or certificate.

(3) If issued on an expense incurred basis, provide benefits which are equal to at least seventy-five percent (75%) of the per diem cost incurred by the insured.

(f) At a minimum, upon the initial effective date of the qualified rider, which provides home and community based services, the qualified rider must provide a maximum benefit amount for the home and community care that:

(1) is at least fifty percent (50%) of the then current maximum total benefit amount of the long term care facility policy or certificate; and

(2) does not exceed the then current maximum benefit amount of the long term care facility policy or certificate.

(Department of Insurance; 760 IAC 2-20-36.3; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2652; filed Jul 28, 1997, 1:50 p.m.: 20 IR 3373; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1996; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-37 Reporting requirements (Repealed)

Sec. 37. *(Repealed by Department of Insurance; filed Feb 9, 1999, 5:02 p.m.: 22 IR 2001)*

760 IAC 2-20-37.1 Reporting requirements

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 37.1. Unless otherwise noted, the following requirements refer to issuer documentation and reporting requirements for qualified policies and certificates:

(1) The reporting requirements shall adhere to the specifications put forth in the Partnership for Long Term Care Insurance Uniform Data Set (UDS) Manual. A printed copy of the Indiana Long Term Care Program reporting requirements and documentation shall be provided, upon request, by OMPP. Reports shall adhere to the most recent UDS specifications, including, but not limited to:

(A) reporting frequencies;

(B) file structures;

(C) file triggers and formats;

(D) field definitions; and

(E) state specific requirements as noted in the Indiana Long Term Care Program section of the state specific appendices of the UDS manual.

(2) All reports are due to OMPP no later than thirty (30) days after the close of the reporting periods specified for the respective reports.

(3) The reporting requirements may vary over time and will adhere to the most current requirements as specified in the UDS Reporting Requirements and Documentation Manual.

(Department of Insurance; 760 IAC 2-20-37.1; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1996; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-37.2 Reporting of agent data

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 37.2. Issuers of qualified policies or certificates shall submit agent sales data to OMPP two (2) times per year for purposes of creating and maintaining a directory of agents for consumers. The format, time frame of reporting periods, and due date for data will be specified by OMPP. *(Department of Insurance; 760 IAC 2-20-37.2; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1997; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-38 Maintaining auditing information

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 38. (a) Each issuer shall maintain information as stipulated in subsection (f) on all policyholders or certificateholders who have ever received any benefit under the policy or certificate. Such information shall be updated at least quarterly. This requirement for updating shall not require the conduct of any assessment, reassessment, or other evaluation of the policyholder's or certificateholder's condition which is not otherwise required by federal or state statute or regulation.

(b) When a policyholder or certificateholder who has received any benefits dies or when a policyholder or certificateholder who has received any benefits lapses his or her policy or certificate for any reason, the issuer must retain the stipulated information for a period of at least five (5) years after the time the policy or certificate ceases to be in force or after the documented death of the policyholder or certificateholder. Unless notified by the department of insurance to the contrary during this period, after the five (5) years, the service summary provided by the issuer will be deemed to comply with all asset protection reporting, record keeping, and auditing requirements of this rule. The issuer may use microfiche, microfilm, optical storage media, or any other cost effective method of record storage as alternatives to storage of paper copies of stipulated information.

(c) At the time the policy or certificate ceases to be in force, the issuer shall notify the policyholder or certificateholder of his or her right to request his or her service records as stipulated in subsection (f).

(d) The issuer shall also, upon request in writing, provide such policyholder or certificateholder or the policyholder's or certificateholder's authorized designee, if any, with a copy of the issuer's service records as required in subsection (f) which are necessary to establish the asset disregard. These records shall be provided to the policyholder or certificateholder or the policyholder's or certificateholder's authorized designee, if requested, within sixty (60) days of the request. The issuer may charge a reasonable fee to cover the costs of providing each set of requested service record copies.

(e) The issuer shall enclose with the records a statement advising the former policyholder or certificateholder that it is in his or her interest to retain the records if he or she may ever wish to establish eligibility for Medicaid.

(f) The information to be maintained includes the following:

(1) Evidence that the insured event has taken place. The occurrence of the insured event may be documented in any of the following ways:

(A) By case management agency staff, as part of the initial assessment of the client or as part of a subsequent reassessment.

(B) By an assessment conducted as part of the preadmission screening program of DDARS.

(C) By an assessment of a resident of a nursing facility as required by Section 1919(b)(3) of the Social Security Act.

(D) For persons for whom clauses (A) through (C) are not available or do not provide the required information, by an assessment, carried out by or under the supervision of a physician or a registered nurse, which is substantially comparable to any of the methods in clauses (A) through (C). These assessments must be based on direct observations and interviews in conjunction with a medical record review. The physician or registered nurse carrying out or supervising the assessment must sign and certify the completion of the assessment. Each individual who completes a portion of such assessment shall sign and certify as to the accuracy of that portion of the assessment.

(2) Description of services provided under the policy or certificate, including the following:

(A) Name, address, phone number, and license number, if applicable, of provider.

(B) Amount, date, and type of services provided, and whether the services qualify for asset protection.

(C) Dollar amounts paid by the issuer, whether on an indemnity, expense incurred, or other basis.

(D) The charges of the service providers, including copies of invoices for all services counting towards asset protection.

(E) Identification of the case management agency, if applicable, and copies of all assessments and reassessments.

(3) In order for home and community based services to qualify for asset protection, these services must be in accord with a plan of care developed by a case management agency. If the policyholder or certificateholder has received any benefits delivered as part of a plan of care, the issuer must retain the following:

(A) A copy of the original plan of care.

(B) A copy of the plan of care required by DDARS.

(C) A copy of any changes made in the plan of care. The plan of care must document that the changes are required by changes in the client's medical situation, cognitive abilities, behavioral abilities, or the availability of social supports.

Such services shall count towards asset protection after the case management agency adds the documented need for and description of the new services to the plan of care. In cases when the service must begin before the revisions to the plan of care are made, the new services will only count towards asset protection if the revisions to the plan of care are made within ten (10) business days of the commencement of the new services. Issuers must maintain initial assessments and subsequent reassessments as part of insured event documentation.

(Department of Insurance; 760 IAC 2-20-38; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1155; filed Jun 15, 1994, 10:00 a.m.: 17 IR 2653; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1997; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)

760 IAC 2-20-38.1 Determining asset protection

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 38.1. (a) Total asset protection for an individually owned qualified policy or certificate is earned when:

(1) the policy or certificate includes a maximum benefit equal to or greater than the state-set dollar amount in force on the original effective date of the policy or certificate;

(2) the maximum benefit was not reduced by the request of the policyholder or certificateholder during the term of the policy or certificate; and

(3) all of the qualified policy or certificate benefits have been exhausted.

(b) Total asset protection for a qualified policy or certificate that has had a reduction of coverage during the term of the policy or certificate is earned when:

(1) the policy or certificate includes a maximum benefit equal to or greater than the state-set dollar amount in force on the original effective date of the policy or certificate;

(2) the maximum benefit was reduced at the request of the policyholder or certificateholder during the term of the policy or certificate, and, at the time of the reduction, the new maximum benefit was equal to or greater than the state-set dollar amount in force during the calendar year in which the reduction took place disregarding any qualifying insurance benefits the policyholder or certificateholder may have already received from the policy or certificate being reduced; and

(3) all of the qualified policy or certificate benefits have been exhausted.

(c) Total asset protection for a qualified policy, certificate, or rider that allows spouses to share the benefits is earned when the policy or certificate includes a maximum benefit equal to or greater than the state-set dollar amount in force on the original effective date of the policy or certificate, and either:

(1) only one (1) spouse uses the policy or certificate benefits and exhausts all of the qualifying insurance benefits; or

(2) both spouses use the policy or certificate benefits and the remaining maximum benefit at the time the first spouse has permanently stopped using benefits is equal to or greater than the state-set dollar amount in force during that calendar year disregarding any qualifying insurance benefits the second spouse may have already received, and the second spouse exhausts the remaining qualifying insurance benefits.

(d) Dollar-for-dollar asset protection is earned for all other situations, which differ from (a), (b), and (c) *[subsections (a) through (c)]*.

(e) A qualified long term care insurance policy or certificate owned by an Indiana resident which was purchased as part of another state's Partnership for Long Term Care Program will earn dollar-for-dollar asset protection for the qualified insured if the other state's program is similar to the Indiana Long Term Care Program and OMPP has a reciprocity agreement with the other state's Medicaid program.

(f) Benefits paid in excess of the actual charges do not earn asset protection.

(g) Benefits paid that are not based upon the insured event criteria do not earn asset protection.

(h) Home and community care benefits paid without case management do not earn asset protection. *(Department of Insurance; 760 IAC 2-20-38.1; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1998; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-39 Reporting on asset protection

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 39. (a) Each issuer shall send an asset protection report at least quarterly, with a copy sent to OMPP, to each policyholder or certificateholder who has received any benefits since the last asset protection report sent to the policyholder or certificateholder. Each asset protection report shall include the following information and shall appear in a format prescribed by OMPP:

(1) The amount of asset protection for which the policyholder or certificateholder had qualified prior to the quarter covered by the report.

(2) The total benefits paid by the issuer for services rendered during the quarter.

(3) A statement of the amount of benefits paid by the issuer for services rendered during the quarter which qualify for asset protection.

(4) A summary total of the amount paid to date under the policy or certificate that qualifies for asset protection.

(b) Asset protection reports shall be subject to audit by OMPP serving as representative of the commissioner of the department of insurance under the same requirements as specified in section 41(2) of this rule which covers the records in section 38 of this rule. *(Department of Insurance; 760 IAC 2-20-39; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1156; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1998; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-40 Preparing a service summary

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 40. (a) Each issuer shall prepare a service summary at the client's request specifically for the policyholder or certificateholder applying for Medicaid. The issuer shall also prepare a service summary when the policyholder or certificateholder has exhausted his or her benefits under the policy or certificate or when the policy or certificate ceases to be in force for a reason other than the death of the policyholder or certificateholder, whichever occurs first. The issuer shall send the service summary to the policyholder or certificateholder, with a copy sent to OMPP, within thirty (30) days of the date of final payment of qualifying insurance benefits by the issuer.

(b) The service summary shall include the following and shall appear in a format prescribed by OMPP:

(1) The specific qualified policy or certificate.

(2) The total benefits paid for services rendered to date.

(3) The amount qualifying for asset protection.

This service summary is separate and in addition to the information requirement described in section 38 of this rule. *(Department of Insurance; 760 IAC 2-20-40; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1156; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1999; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-41 Plan of action

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2; IC 12-15-39.6

Sec. 41. (a) Each issuer shall, prior to qualification by the department of insurance, submit to OMPP a plan for complying with the information maintenance and documentation requirements set forth in sections 37.1 and 38 of this rule. No policy or certificate shall be qualified until OMPP has approved the issuer's documentation plan for the policy or certificate. The documentation plan will include the following:

(1) The location where records will be kept. Records required for purposes of the Indiana long term care program must be available at no more than three (3) locations, each of which shall be easily accessible to OMPP serving as representative of the department of insurance.

(2) The issuer shall agree to give OMPP access to all information described in section 38 of this rule on an aggregate basis for all policyholders or certificateholders and on an individual basis for all policyholders or certificateholders who have ever received any benefits. Access to information on persons who have not applied for Medicaid is required in order to determine if an issuer's system for documenting asset protection is functioning correctly. The OMPP shall have the final decision concerning the frequency of access to the data and the size of samples for auditing or other purposes.

(3) The name, job title, address, and telephone number of the person primarily responsible for the maintenance of the information required and for acting as liaison with OMPP and the department of insurance concerning the information.

(4) Methods for determining when insurance benefits or prepaid benefits qualify for asset protection, including the following:

(A) Documentation of the insured event.

(B) Description of services.

(C) Documentation of charges and benefits paid.

(D) Documentation of plans of care, when required.

(5) Description of electronic and manual systems which will be used in maintaining the required information.

(6) Information that will be retained which is needed to comply with this rule.

(7) Copies of forms and descriptions of standard procedures for maintaining and reporting the information required, including the specific electronic medium that will be used to report required information and a description of the relevant files.

(b) After OMPP reviews a plan of action, OMPP shall advise the department of insurance and the issuer in writing whether OMPP approves the plan of action. If OMPP disapproves a plan of action, OMPP shall advise the department of insurance and the issuer of the shortcomings in the plan of action and shall instruct the issuer of the methods necessary to resolve them. *(Department of Insurance; 760 IAC 2-20-41; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1156; filed Feb 9, 1999, 5:02 p.m.: 22 IR 1999; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-42 Auditing and correcting deficiencies in issuer record keeping

Authority: IC 27-8-12-7.1

Affected: IC 12-15-2; IC 12-15-39.6

Sec. 42. (a) Within one (1) year of the first date that any policyholder or certificateholder of a particular issuer's policy or certificate has met the criteria for the insured event, and as often as the commissioner or OMPP deems necessary thereafter, OMPP as representative of the commissioner shall conduct a systems audit of that company's records. The issuer shall be responsible for advising OMPP and the department of insurance when this one (1) year period has begun. OMPP shall promptly inform each issuer of inaccuracies and other potential problems discovered in its systems audits, and shall instruct the issuer of the methods necessary to correct any problems in the issuer's methods of operation. It is the responsibility of the issuer to make any necessary corrections.

(b) OMPP shall periodically reconcile a sample of individual applications to Medicaid of persons who have submitted documentation for qualification for asset protection with the reports submitted by issuers. OMPP shall have the final decision concerning sample sizes and other auditing methods. OMPP shall promptly advise issuers of any problems discovered and shall instruct the issuer of the methods necessary to correct any problems in the issuer's method of operation. OMPP shall also notify the issuer of any obligations described in this subsection to hold clients harmless.

(c) The assistant secretary of OMPP or other authorized individual may enter into voluntary arrangements with issuers of qualified long term care insurance policies and certificates under which the assistant secretary would issue binding determinations as to whether or not services qualify for asset protection. Policyholders or certificateholders may submit requests for information and advice through their issuer or case management agency. When the following procedures are followed in all material respects, the written determinations of the assistant secretary of OMPP or other authorized individual concerning whether services qualify for asset protection shall be binding upon OMPP in all subsequent actions, and OMPP shall not make any assertion contradicting these determinations in any action arising in this subsection:

(1) All requests for determinations as to whether or not services qualify for asset protection shall be submitted to the assistant secretary of OMPP or other authorized individual in writing. These requests may include, but are not limited to, requests for determinations in the following areas:

(A) Whether the insured event has occurred and has been adequately documented.

(B) Whether a care plan is required.

(C) Whether a revision of a care plan is required.

(D) Whether a service or services are in accord with the care plan.

(E) Whether a service is of such a nature as to qualify for asset protection.

(F) Whether the applicable amount is the amount paid by the issuer or the amount charged for the service.

(2) The assistant secretary of OMPP or other authorized individual may require issuers and case management agencies submitting requests for determination to provide all records and other information necessary for making a determination. The records and other information may include, but are not limited to, the following:

(A) Assessments.

(B) Care plans.

(C) Invoices for services rendered.

The party providing the records and other information shall be responsible for their accuracy. If any records or other information are *[sic., is]* later determined to be materially inaccurate, the determination based on the inaccurate information shall be void and not be binding on OMPP or any other person or entity in subsequent actions. In the case of a policyholder or certificateholder for whom a determination has been invalidated because information provided was determined to be inaccurate, the provisions of subsections (f) and (g) will apply in the same manner as for any other policyholder or certificateholder.

(3) The assistant secretary of OMPP or other authorized individual shall render his or her determination on each request in writing. Each determination of the assistant secretary of OMPP or other authorized individual shall state the reason for his or her determination, including the following:

(A) Relevant facts.

(B) Documentation of facts.

(C) Statutes.

(D) Regulations.

(E) Policies.

(4) A copy of all determinations of the assistant secretary of OMPP or other authorized individual shall be kept on file at OMPP, together with the related records and information. The original of the determination shall be sent to the issuer or the case management agency that originally requested it. The recipient of the original determination shall be responsible for notifying the policyholder or certificateholder or the policyholder's or certificateholder's authorized agent.

(d) When an audit or other review by OMPP reveals deficiencies in the record keeping procedures of an issuer, OMPP will notify the issuer of the deficiencies and establish a reasonable deadline for correction. If an issuer fails to correct deficiencies discovered by OMPP within a reasonable period of time, OMPP will notify the department of insurance of the deficiencies.

(e) The commissioner of the department of insurance, upon consultation with OMPP, shall reserve the right to remove qualification status of long term care insurance policies and certificates when deemed necessary. Failure to comply with any of the provisions of this article can be grounds for the removal of qualification status. If the department of insurance removes qualification status from a long term care insurance policy or certificate, a policyholder or certificateholder who purchased his or her policy or certificate while the policy or certificate was qualified will retain his or her right to asset protection. A policyholder or certificateholder who purchases his or her policy or certificate after the removal of qualification status will have no right to asset protection. Any issuer who has their qualification status removed must continue to comply with the reporting requirements and maintaining auditing information requirements set forth in this article.

(f) If an issuer prepares a service summary which is used in a Medicaid application for a policyholder or certificateholder and the client is found eligible for Medicaid, and the policyholder or certificateholder after receiving Medicaid services is found to be ineligible for Medicaid solely by reason of errors in the issuer's service summary or documentation of services, OMPP may require the issuer to pay for services counting towards asset protection required by the policyholder or certificateholder until the issuer has paid an amount equal to the amount of the issuer's errors; after which the policyholder or certificateholder, if otherwise eligible, could qualify for Medicaid coverage.

(g) If OMPP determines that an issuer's records pertaining to a policyholder or certificateholder who has received Medicaid benefits are in such condition that OMPP cannot determine whether the policyholder or certificateholder qualifies for asset protection, OMPP may require the issuer to pay for services counting towards asset protection required by the policyholder or certificateholder until the issuer has paid an amount equal to the amount of the issuer's error; after which the policyholder or certificateholder, if otherwise eligible, could qualify for Medicaid coverage.

(h) OMPP shall serve as the representative of the commissioner for all audits and examinations that may be required to determine compliance with this article.

(i) Compliance with subsections (f) and (g) is a requirement for a policy or certificate to retain qualification. *(Department of Insurance; 760 IAC 2-20-42; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1157; filed Feb 9, 1999, 5:02 p.m.: 22 IR 2000; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

760 IAC 2-20-43 Separability

Authority: IC 27-8-12-7.1
Affected: IC 12-15-2

Sec. 43. If any provision of this rule or the application thereof to any person or circumstance is for any reason held to be invalid or unenforceable, the remainder of the rule and the application of such provision to other persons or circumstances shall not be affected thereby. *(Department of Insurance; 760 IAC 2-20-43; filed Nov 20, 1992, 9:00 a.m.: 16 IR 1159; readopted filed Sep 14, 2001, 12:22 p.m.: 25 IR 531)*

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